Patient Reaction
to the Teaching and Research Situation*

JULIUS B. RICHMOND, M.D.†
State University of New York Upstate Medical Center, Syracuse, New York

I am delighted at the opportunity to discuss with a captive group of University Hospital administrators the matter of patient reactions to the teaching and research situation. My delight is borne not out of hostile impulses for administrators (I say this since I assume that almost all professionals feel that they have at some time or another suffered undue frustration at the hands of administrators), but rather because of the opportunity to discuss—as collaborating professionals—a problem with which we are equally concerned. In short, I do not feel that the faculty or the administrative officers in a University Hospital have an exclusive or proprietary interest in the patient and his care. Rather, since the service to patients is the central focus about which teaching and research centers, it becomes important that we work toward the provision of the highest quality service, administered in the most sensitive way possible.

Since much has already been said about the quality of patient care and its evaluation in teaching hospitals, I will not dwell on this aspect of the subject. The central problem of this discussion is epitomized in the first paragraph of the article “The Decline of the Healing Art,” by Selig Greenberg, which appears in the October 1960 issue of Harper's. He states, “In the loneliness and terror of illness, we become helpless and childishly dependent. Above all, we need love. But this today's physician seldom has time or inclination to give. The patient's sense of unrequited love reflects a major failure of modern medicine which is an even more widespread source of discontent than its high cost. The hasty, superficial, and impersonal treatment rendered by overworked doctors is the commonest complaint in current opinion samplings.” Although Greenberg speaks of the healing art generally, his point is entirely applicable to the teaching and research situation. The challenge is before us. Systematic studies of patient reactions to the teaching and research situation have been few and have been mainly limited to psychiatric hospitals. We therefore must rely predominantly on our convictions for action.

At the outset, I would like to emphasize a guiding principle I have always held before me: that is, that administration should serve program. I know that this may be platitudinous to mention in a meeting of hospital administrators, for indeed this is probably the basic principle taught in “Hospital Administration” at any school for hospital administrators. It may, however, bear repeating by an individual who has had no formal preparation in this field. I feel that administrators cannot serve program effectively if their concern and professional background are exclusively related to administrative problems and not to

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†Chairman, Department of Pediatrics.
the content of the program. It becomes important, therefore, that administrators have a wholesome awareness of the problems of patients and their individual needs—what we might designate as the psychology of patient care.

It might be appropriate to present a brief historical overview of clinical teaching in the early decades of this century. When clinical teaching centered largely about description, there was considerable emphasis on having the student see a large number of patients; since we were in an era of descriptive medicine and the medical school program constituted the terminal educational experience for the student, it was appropriate to attempt to have the student “see everything.” The utilization of our large public hospitals as the major centers for teaching (although they were not planned for teaching) facilitated this tendency. Thus, two purposes were served: first, there was provided a large volume of medical care; and, second, students were given an opportunity to see vast numbers of patients whom they could categorize descriptively.

I mention this period in medical education because I believe it left us with some residue with which we have not yet adequately dealt. In the milieu of the large public hospital young students caring for vast numbers of patients had to develop some capacity for self-protection from the many—and often intense—social problems which patients brought with them. A major protective device was insulation from the personal problems of the patient by immersion in the biological problems. To inquire into all these problems would have been much too great a load for most young students to deal with. I mention this not in any critical fashion, but rather to understand the problems which students in that era faced as well as to indicate that the issues we face in providing sensitive patient care today are not new. As we look toward progress, we have no reason to long for the “good old days.” From my personal experience as a house officer, I would wonder whether students could have survived had they not developed this kind of defensive armour of insensitivity, at least at the superficial level. Indeed, in retrospect, much of the house staff jocularity which was observed under such circumstances was part of the defensive maneuver—the effort to deny the tribulations under which the house staff worked. Again, I wish to emphasize that I am not being judgmental; rather I am attempting to define some of the dynamics of the learning process.

We have now emerged into an era of dynamic biology in medicine in which the emphasis is on an understanding of process rather than on description and categorization. The result has been that we no longer rely on large numbers of patients for effective clinical teaching. Rather, the advances in biochemistry, microbiology, physiology, pharmacology, and investigative techniques have complicated the study of patients and rendered it impossible for a student to care for many patients.

With the development of a more dynamic biology has also come a greater awareness of psychological aspects of patient care—the influence of the psychology of the patient on his physical illness, and vice versa. In this connection I believe it is important to note that we are talking about aspects of patient care which it is commonly said the “old family doctor” cared for so capably. Without attempting to detract from the “old family doctor” I believe it is necessary to indicate that our emphasis is now on teaching the young doctor to have the same degree of wisdom and facility in caring for the psychological needs of patients which the old family practitioner had. It is interesting to note that, when people talk about the old family doctor,
there is emphasis on the word old. We are now trying to teach students to have the same compassion and skill in the management of their patients which the practitioner of yesteryear spent decades developing. Our modern knowledge of psychology, sociology, cultural anthropology, and psychiatry should enable us to accomplish this objective somewhat earlier.

The rapid changes in the sociology and economics of medical care are also pressing us—and I believe very desirably so— to consider the patient's psychological needs more comprehensively. The development of insurance programs of various kinds, including governmental programs such as state aid for handicapped children and medical care for the aged, potentially provide the patient with greater choice in selecting his medical care. Certainly if the teaching hospital does not satisfy the patient and his family, it is altogether likely that the patient will go elsewhere. The emergence of many effective private group practices makes it perfectly possible for patients to receive even complex diagnostic and therapeutic care in a nonuniversity hospital setting. Indeed, the large private clinics have developed skills in dealing with patient's personal needs to an extent that many of our university hospitals would do well to emulate.

In a discussion of patient reactions to the teaching hospital, it becomes necessary to try to define the patient's problems as he enters the teaching setting. In the setting of the vast physical structure of the modern out-patient department and hospital, the patient often enters with some degree of depression, anxiety concerning separation, and certainly considerable preoccupation with himself. It is small wonder that he is considerably confused by the complexity of the physical plant and the multiplicity of people circulating about with varying degrees of authority and officiousness. At the extremes of life—the very young and the elderly—the confusion and loneliness are accentuated. We should also remember that specific psychological difficulties may be precipitating factors in bringing a patient to the hospital even when his illness seems primarily physical. This problem has been the object of study by Drs. Schmale and Engel at Rochester over the past several years. Their studies indicate that a significant number of patients admitted to a general medical service have undergone a significant separating experience or threat of separation within one week prior to admission.

Although we could become quite psychological in discussing our efforts to meet the patient's needs, I am electing to deal with this problem in operational terms. In other words, our concern is with the practical aspects of programming which will provide most adequately and comfortably for the patient. Perhaps the basic need of the patient is for respect. If the patient is not treated with respect, it becomes difficult for him to have self-respect. Without self-respect, it may be difficult for him to muster his resources in a way which will enable him to deal with both his biological and his environmental problems. Conversely, however, we have seen many effects which I would consider to be distinctly positive under more optimal conditions—effects which I often refer to as psychotherapeutic effects in a non-psychotherapeutic setting. In our pediatric out-patient and in-patient departments, we have seen families headed down the road toward social disorganization and disintegration gradually reverse their direction toward better integration both within the family and within the community—not because of formal psychotherapeutic efforts, but rather based on a relationship of mutual respect. Out of such a relationship comes status and dignity.
How can we communicate our respect for the patients who come under our care in operational rather than psychodynamic terms? In effect what I am suggesting is a check-list around which we can examine our services, because respect is born out of the “little things” which make the “big difference.” For years I have intuitively made evaluations of the sensitivity of patient care as I visited other services. The following are some of the common denominators which seem of considerable significance to me.

1. Respect for identity. One of the basic building blocks in any program of patient care should be an opportunity to relate primarily to one person on the staff. In these days of revolution in biochemical genetics we teach one gene— one enzyme; it might be well for us to coin an analogous aphorism: one patient—one doctor. The private clinics have tended to be quite effective in this direction. Our large teaching hospitals, however, can be similarly effective. We have found it desirable, for example, to have every child admitted to the pediatric clinic as his “home” clinic. Thus, no matter where the patient and parents go, there is a central figure who will provide interpretation and serve to reduce anxiety about uncertainty which is associated with new consultations and procedures. This is more work for us to be sure, but there is no alternative, we feel, in providing high-quality services. This function, unfortunately, cannot be delegated to a nonmedical person, since the gathering of all of the data and its interpretation necessarily require a medical background. Also, the history which we obtain is richer and more meaningful if there is a relationship with one physician. Over a period of time confidence develops which permits the elicitation of more data than occurs on an equal number of visits to a variety of physicians. Even though we necessarily rely heavily on house staff for patient’s contact, it is possible to build in continuity of care if we are alert to its significance. As house officers change, provision can be made for the transfer of patients to facilitate continuity. Staff physicians can often serve in a bridging fashion to provide the continuity without necessarily taking over the care of patients. We have not been sufficiently imaginative in our programming to resolve this problem adequately.

In visiting a hospital one can get a feeling very early concerning the sensitivity of patient care by noting how patients are addressed. Is Mr. Smith referred to rather anonymously as “Dad” or room number 402, or is he Mr. Smith regardless of his social and economic status? Does the child have a name by which he is addressed, or is he referred to as “the case of leukemia”? Do we know his nickname and eating and toiletting habits? Little things, we might say, but the substance out of which relationships and the feelings about relationships and a sense of identity are conveyed.

Another aspect of respect for the individual may be manifested by the matter of visiting hours. Are visiting hours conducted in relationship to the patient’s needs, or do they reflect some circumscribed schedule that the nurses have conjured up, or is it a schedule which has been in existence for decades without anyone’s ever having taken the trouble to reexamine it? We have found that in many instances nurses have had misconceptions about the desirability of a family’s stay in the hospital. On our pediatric service, for example, when we were doing a study of the effects of folic acid antagonists on acute leukemia, we asked the parents to stay with the more critically ill children as freely as they would like. At first the nurses were highly resistant to this; but after a period of months, they found that the presence of the parents made it con-
siderably easier to deal with the children and that the parents were helpful in many instances—not alone in the care of their own children, but in the care of other children on the service.

2. Respect for privacy. Again, regardless of economic status each individual has some need for privacy. Are the interviews conducted in an area where there is an opportunity to talk without being overheard? Many of our hospital wards do not have adequate provisions for this degree of privacy. In relationship to physical examinations, is there appropriate provision for privacy? I believe we could do well, too, to re-examine our need to have multiple individuals examining and re-examining patients. Again it is necessary to point out that the student will not see everything which he is to see in his lifetime during his student years. Certainly he has, in most instances, 3-4 years of house officer training before him, and there would appear to be little reason to subject patients to an inordinate number of examinations.

The matter of ward rounds and conferences at the bedside is another indication of the respect for the individual. Again we need to examine our time-honored practices. The matter of the entourage of the chief and all of the house staff and students trailing behind as a teaching exercise could well be questioned. Now that we have tended to introduce classrooms on our wards, I see little purpose which is served by parading up and down the wards. It seems to me that most of the pertinent issues concerning patients can be discussed in the classroom more comfortably and with a blackboard available and either the patient brought to the group or the group in turn making a rather brief visit to the bedside. The prolonged conversations at the bedside, I believe, are almost without merit—and in many instances actually traumatic as an invasion of privacy—for the patient, and certainly are not very informative for students. Again is this not a carry-over from the days when teaching took place in what were essentially nonteaching hospitals?

3. Respect for time. This perhaps is one of the more subtle aspects of conveying to the patient that we have some degree of respect for him. This is a particular problem in the out-patient department and in admitting procedures for the in-patient service. One screening test is to define the length of time between arrival at the admitting office and the patient's being situated comfortably in bed. I daresay that in most teaching hospitals this is still a very considerable period of time. On a service with which I was affiliated we reduced this time by 3 hours at one point, simply by paying some attention to details and removing some of the thoughtless roadblocks. Since the patient arriving at the hospital is often preoccupied, somewhat depressed, and anxious about separation, prolonged waiting only increases his anxiety.

In the out-patient department, particularly, students often will take inordinate lengths of time to obtain a history. The assumption is made that, particularly for patients of low socio-economic status, their time is worth nothing and is available only to the student. Not too long ago I encountered a situation in which a student had taken 2½ hours to elicit a history and was rather perturbed that the mother of the child felt that she had to terminate the session in order to get home. He had no awareness of the fact that her school-age child was due home from school and no one would be there to meet him or to prepare his lunch if she were not home. One would also raise the question as to whether any interview is productive after a period of an hour.

Another aspect of respect for the patient's time relates to the matter of appointment systems. One can get a good
feel of the sensitivity of a program of patient care by noting whether there is an appointment system in an out-patient clinic or whether the patients are all instructed to come early in the morning and early in the afternoon and then wait their turn at the convenience of the doctor.

Out of these relationships the patient has the potentiality for developing confidence in the institution. However, we should emphasize that the patient's confidence is not in relation to the mortar and bricks of the institution, but rather to people within it.

All the problems I have mentioned up to now can be dealt with most effectively in the teaching situation by example. It seems to me that, if the faculty members are sensitive to patients' needs, the student will soon identify this sensitivity and respond to it. Certainly he will recognize the respect and empathy which the physicians on the faculty have for their patients.

This raises a central question, therefore, concerning the matter of dealing with patient reactions to the teaching hospital. The central question relates to the sensitivity of the teaching faculty in dealing with these issues. It seems to me that, in recruiting faculty for clinical teaching, this should be a very basic aspect of the evaluation of the competence of the individual. I am not suggesting that investigative skills are unimportant; but if a person is to be a clinical investigator, it seems to me that he must have some capacity to empathize with the patient. If he does not, he might more appropriately remain an investigator in the basic sciences.

I would in this connection like to put to rest what I believe to be a myth in relationship to clinical teachers—that the private practitioner has greater capacities than the full-time teacher. In my opinion, this has little to do with the method of practice. It has to do with the individual's orientation toward the people for whom he cares. I have seen insensitivity in practicing physicians in the same way that I have seen insensitivity in full-time clinical teachers. I should, however, mention that on some occasions the practitioner group is less responsive to patients of lower socioeconomic background than our full-time faculty members. Many of our private practitioners practice in a relatively narrow stratum of the population and have less awareness of the needs of people in other social groups than may some of the full-time faculty. I am not suggesting, however, that either one of these groups has a monopoly on empathy for patients.

I do wish to leave the emphasis that respect for human beings who come to us for medical care is something which to a considerable extent can be taught. If I had no confidence in this, I would tend to place my reliance exclusively in the selection process for medical school admissions. Since we cannot, however, rely on any kind of selection procedure to provide us with human beings as medical students who will have all the potentialities for providing sensitive patient care, we must have confidence that this approach can be taught. I believe it is possible for a young student to acquire over a period of years some respect for the needs of individuals largely through the process of emulating the senior members of the profession who are charged with teaching him. What the student often needs is the sanction to be curious and friendly. This is the challenge for faculty members in the teaching hospital; the challenge to hospital administrators is to facilitate programs which make possible the provision of sensitive patient care which should characterize the teaching hospital—even in the face of its complexity.